From: eNotify@payflex.com

Sent: <Day>, <Month> <Date>, <Year> <Time>

To: <email address>

Subject: Claim Payment from PayFlex – Action May Be Required

Attachments: Explanation of Payment – Reimbursement via Check

Dear <Name of Participant>:

Thank you for submitting your claims(s) to PayFlex. We have processed your claim(s) and your reimbursement check will be mailed to you. Remember, you can enroll in direct deposit by logging into <URL> and selecting **My Accounts and Services** on the left-navigation bar, then select **Enroll in Direct Deposit**. Simply enter your bank account information and click **Next** to receive your next reimbursement via direct deposit. If a claim has been denied, you may be required to take action. If action is required, please provide the requested documentation or payment, as the case may be, to PayFlex via fax or mail.

Thank you,
PayFlex Systems USA, Inc.
<URL>
XXX.XXX.XXXX (customer service)
XXX.XXX.XXXX (fax)

DO NOT REPLY TO THIS EMAIL. This was sent by an automated system. "Reply" messages are automatically deleted and will not receive a response.

LAST NAME, FIRST NAME
Employer Name

Explanation of Payment
(Reimbursement)

Thank you for submitting your claims(s) to PayFlex. We have processed your claim(s) and your reimbursement notification is attached. Below is a summary of the claims being paid. If a claim has been denied, you may be required to take action. If action is required, please provide the requested documentation or payment, as the case may be, to PayFlex via fax or mail.

Check #: XXXXXXXXX Check Date: 07/05/2012 Total Check Amount: **** $200.00

Your Account Balance After This Payment

Account Name	Annual Election	Deposits	Total Paid	Election Remaining	Amt This Payment
(2012) Healthcare (FSA)	$2,000.00	$1,992.92	$2,000.00	$0.00	$200.00

This Payment Includes

Account Name	Expense Type	Service Dates Begin	Service Dates End	Amt Requested	Amt Paid	Amt Denied	Claim #	Amt This Payment
(2012) Healthcare (FSA)	Dental	07/01/12	07/01/12	$215.26	$200.00	$15.26	XXXXXX	$200.00
Denied Reason: Plan year election has been met								
						Total:		$200.00

Access your account information online at <URL>
PayFlex Systems USA, Inc. I P.O. Box 3039 I Omaha, NE 68103-3039
Toll Free: (XXX) XXX-XXXX I Fax: (XXX) XXX-XXXX

You have the right to request upon appeal, a review and a copy of any internal procedures or guidelines used during the processing of your claim. Your request must be in writing within 180 days of receiving this explanation of payment. A review will be conducted and you will be notified by the plan administrator (or designated claims fiduciary) of the decision within 60 days (30 days if your plan has 2 levels of appeal). Please refer to your Summary Plan Description for additional information regarding any second level appeal that may be available to you under the plan (such as your time period for filing an appeal (which may be less than 180 days)) and where to file the appeal. After you have exhausted the plan's required appeal procedures, you have the right to bring civil action if you file a request for review and your request for benefits is denied. Note: Plans such as Dependent Care, Tuition Reimbursement and Transportation are not subject to ERISA or subject to this process.